FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED. AND PLAN OF CORRECTION A. BUILDING: ___ B. WING 09/15/2020 IL6000756 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET HERITAGE HEALTH-JACKSONVILLE JACKSONVILLE, IL 62650** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S 000 S 000 Initial Comments Complaint survey 2047135/IL126638 - F689 G S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest Attachment A practicable physical, mental, and psychological

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

Electronically Signed

TITLE

Statement of Licensure Violations

(X8) DATE 10/30/20

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:		COMP		
		IL6000756	B. WING		I	C 09/15/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
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S9999	care needs of the resident of a facility series dent. (Section 20.3240 A) An owner, licensagent of a facility series Regulations by: Based on interview review the facility fand follow interven reviewed for falls. Thaving 11 falls from 2020. The Septemi	e total nursing and personal resident. Restorative lude, at a minimum, the es: o subsection (a), general include, at a minimum, the be practiced on a 24-hour, basis: ary precautions shall be taken residents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. Abuse and Neglect see, administrator, employee or hall not abuse or neglect a	\$9999				
	part, "Risk for falls gait secondary to C	ted 5/12/2020, documents, in due to impaired balance and CVA (stroke) with left sided nt frequently chooses to get up					

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(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING:		COMPLETED		
IL6000756		B. WING		C 09/15/2020			
• • • • • • • • • • • • • • • • • • • •	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S9999	and ambulate without despite frequent teal Interventions: 6/1/2 on at all times to not gotten up without a Resident and POA bathroom stating "ounattended in bathremoved and floor Transfer status ass of 2." R1's Minimum Data documents extensit transfers and toiletistabilize with staff a off the toilet. Arm a side. R1's Health Status PM, documents "O in front of the toilet. verbalized res had movement). While the toilet to grab movement). While the toilet and her woo.6cm skin tear to eye glasses being face. Noted 4cm X X 1 cm red abrasio 8cm X 1cm red abrasio 8cm X 1cm red abrasio 8cm X 1cm red abrasio 9cm extendities WNI resident. Res denied	out asking for staff assist aching and reminders. 020 Bed/WC alarm applied, otify staff that resident has sking for assist. 6/19/20 agreeable to sign placed in do not leave resident room. 6/29/20; bed alarm mat alarm applied. 6/29/2020 ressed; resident requires assist as Set, dated 8/5/2020, we assist of 1 person for ring. Not steady, only able to assistance with moving on and and leg impairment on one note, dated 8/22/2020 at 3:06 bserved res sitting on the floor. Res (resident's) aide an extra large BM (bowel res aide stepped away from ore wash cloths res fell. Aide that the aide observed res front of the toilet in between theel chair. Noted a 1cm X the bridge of res nose from respushed to the right side of res 1.5cm, 6cm X 1cm, and 9cm on like area to res left thigh, rasion like area to the middle seisted into her w/c ROM (range of motion) noted to L (with in normal limits) for res hitting her head with no s/s and observed. Res denies	S9999				

(X2) MULTIPLE CONSTRUCTION

PRINTED: 11/24/2020 **FORM APPROVED** Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING IL6000756 09/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE JACKSONVILLE, IL 62650 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 3 R1's C.N.A. and Nurse Post fall Investigation, dated 8/22/2020, documents "Fall Description Details (R1) had an incontinent BM, I went to the next room to get more washcloths when I came back she was on the floor." R1's Health Status Note, dated 9/6/2020 at 11:10 PM, documents "Writer was sitting at desk when writer observed resident walking down the hall after just being put to bed. Resident had been toileted just a few minutes earlier as she was put to bed. CNA states alarm was on when she left room but resident turned alarm off and proceeded to get up from bed being in lowest possible position. Resident lacks the dexterity to turn off the alarm. Resident was observed during this fall and did not hit head. MD and poa (power of attorney) notified." R1's Health Status Note, dated 9/7/2020 at 4:55 PM, documents, "Writer summoned to res room. Upon entering room observed res sitting on her left hip with upper left side of body lying on the floor, right leg extended out with left leg bent in a sitting position, and back against her recliner. Res stated I have to go to the bathroom. Noted a 1.5cm X 0.5cm abrasion to the bridge of nose, 4cm X 4.5cm Red abrasion with a scratch in the center to left knee, 0.6cm scratch/abrasion to left knee, 5.5cm X 1.5cm red area with a 3cm X 0.6cm abrasion in the middle above right eye,

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4cm X 3cm light blue raised area to the center of forehead. Full ROM noted to all extremities. Res denies pains and discomforts with ROM. Denies nausea, verbalizes she does have a headache at this time. Neuro checks initiated per protocol. VS: 140/74, 102, 18, 98.4, 98% RA (room air)"

R1's C.N.A. and Nurse Post Fall investigation. dated 9/7/2020, documents "Fall Description

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meet resident at hospital."

R1's CT (computed tomography) results from an area hospital, dated 9/9/2020, documents "There is fracture of the midportion the right nasal bone and probable acute of the tips of the nasal bones.

On 9/9/2020 at 1050 AM V9, CNA, stated "(R1) was alert and oriented. She has been different since she has been falling. She won't stay still. Forgetful. Forgets what she needs. She needs

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IL6000756

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE HEALTH-JACKSONVILLE

FORM APPROVED

(X3) DATE SURVEY COMPLETED

C 09/15/2020

HERITAGE HEALTH-JACKSONVILLE 873 GROVE STREET JACKSONVILLE, IL 62650						
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\$9999	Continued From page 5	S9999				
	more help now. She has always needed some help but now it takes 2 people. Before it only took 1."					
	On 9/9/2020 at 1105 AM V10, CNA, stated "She had a stroke and her processing is slow. She has delayed speech. Her balance is bad. She has had a lot of falls. She needs 2 people now to transfer her. She has fallen from her chair. Her balance is horrible. She tries to stand but she has the weakness on her left side and when she steps down her foot turns in and she falls. She doesn't protect her face when she falls as you can see with all the bruising. She has a floor mat alarm and a chair alarm. The one (chair alarm) she is sitting on doesn't work. I didn't want to wake her up to put the new one on her. The new one is sitting on her bed. I just didn't want to wake her.	ii .				
	On 9/9/2020 at 1215 PM V12, Licensed Practical Nurse, stated "(R1) has left sided weakness. I just sent her out. She had increased confusion. Multiple falls. She is a fall risk. She does have a UTI (urinary tract infection). And when she has an UTI her fall risk is even higher. She had loss of balance and her speech was slower. She couldn't follow my finger when I was assessing her. She just wasn't acting right. I knew something was wrong. I am really not sure what causes her falls. She doesn't fall on days. Evenings doesn't have as much staff as days do."					
Ilinois Para	On 9/10/2020 at 217 PM V13, CNA, stated "(R1) said she needed to go to the bathroom. I took her to the bathroom and sat her on the toilet. Noticed she had a bowel movement. Didn't have enough towels. Left the room and went next door to get some more. When I came back she was on the floor. I saw blood on the floor that was coming from her nose. She was not supposed to be left in rtment of Public Health			3		

(X3) DATE SURVEY

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STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
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\$9999	the bathroom unater balance is pretty bath She is very unstead on 9/10/2020 at 24 stated "Became far had multiple falls are to her spine. She is multiple falls. I would her with more superfollow the care pland increased (R1's) such care pland by not lead unattended, using the transfers, assuring working it is possible many falls. And if since wouldn't have had the shear that the same that the same transfers is the same transfers in the same transfers.	ended. I knew that. Her ad and I shouldn't have left her. dy." 2 PM V14, Medical Doctor, miliar with patient in 2014 she and had a compression fracture a high fall risk and has had deepect the facility to provide rvision. I would expect them to a lift the staff would have appropriate staff for the chair alarm is in place and the she would not have had as the didn't have the falls she the injuries and the fracture."	S9999				
ę	chair alarm not wor them to replace it in staff to follow the ca have followed the co would not have occ The policy and proce & Management, reve documented under facility to assess ea admission, quarterly help facilitate an inter- care planning to ap and ultimately redurisk will be address "Procedure: F. Inter- fall risk assessment	od "If the staff are aware of a king properly, I would expect mmediately. I would expect the are plan. If the C.N.A. would are plan the fall (8/22/2020)		.2			

(X2) MULTIPLE CONSTRUCTION

PRINTED: 11/24/2020 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ B. WING _ IL6000756 09/15/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET HERITAGE HEALTH-JACKSONVILLE** JACKSONVILLE, IL 62650 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 7 S9999 (B)

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